INTAKE DATABASE

FIRST NAME -- MIDDLE INITIAL -- LAST NAME	DATE OF BIRTH

PRIMARY PHYSICIAN	OTHER PHYSICIAN
OTHER PHYSICIAN	**OTHER PHYSICIAN**
PHARMACY	**HOME HEALTH AGENCY**
LIST YOUR MEDICATIONS BELOW:	**LIST YOUR MEDICATIONS BELOW:**
LIST YOUR DRUG ALLERGIES BELOW:	**LIST YOUR DRUG ALLERGIES BELOW:**
LIST YOUR MEDICAL DIAGNOSES / PAST MEDICAL HISTORY / HOSPITALIZATIONS BELOW:	
LIST THE SURGERIES / INVASIVE PROCEDURES YOU HAVE HAD BELOW:	

What is the location of your pain? ______________________________

Rate your pain (on a scale of 1-10): Current ________ Worst ________ Best ________ Acceptable ________

How would you describe your pain?

- ☐ Intermittent
- ☐ Occasional
- ☐ Continuous

How long have you had this pain? ______________

What is the quality of your pain?

- ☐ Ache
- ☐ Cramping
- ☐ Dull
- ☐ Prick
- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing

What causes an increase in your pain? ______________

What relieves your pain?

- ☐ Medication
- ☐ Relaxation
- ☐ Exercise
- ☐ Heat
- ☐ Elevation
- ☐ Cold
- ☐ Nothing

What parts of your life are affected by pain?

- ☐ Sleep
- ☐ Appetite
- ☐ Concentration
- ☐ Quality of life
- ☐ Emotions
- ☐ Relationship

What is your current pain management plan? ______________

What are your goals for pain management? ______________

FAMILY AND SOCIAL HISTORY

What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widow
- ☐ Widower
- ☐ Significant other

What is your current living situation?

- ☐ Alone
- ☐ With family
- ☐ Nursing home
- ☐ Assisted living
- ☐ SNF (skilled nursing facility)
- ☐ Homeless
- ☐ Other

Do you have a family member or friend that can assist in your care? ☐ Yes ☐ No

What is/was your primary career? ______________

Why did you retire?

How would you describe your current activity level?

- ☐ Active
- ☐ Minimal
- ☐ Sedentary
- ☐ Restricted

How many packs of cigarettes do you smoke a day? ______________

What year did you start smoking? ______________

What year did you stop smoking?

How long does it take you to drink a six pack of beer, fifth of liquor, or botle of wine?

- ☐ Unknown
- ☐ Do not drink
- ☐ A day
- ☐ A week
- ☐ A month
- ☐ 6 months
- ☐ A year

What recreational drugs do you use?
(check all that apply)

- ☐ Marijuana
- ☐ Cocaine
- ☐ LSD
- ☐ Methamphetamines
- ☐ Heroin
- ☐ Other

What was the cause of death of your Mother? ______________

What was the cause of death of your Father? ______________

Are there any other pertinent diseases that run in your family? ______________

REVIEW OF SYSTEMS

Please check (☑) "yes" or "no" if you have had the following symptoms:

CONSTITUTIONAL

	YES	NO		YES	NO
Appetite change	☐	☐	Pain	☐	☐
Chills	☐	☐	Weakness	☐	☐
Fever	☐	☐	Intended weight loss	☐	☐
Insomnia (unable to sleep)	☐	☐	Unintended weight loss	☐	☐
Lethargy (decreased level of alertness)	☐	☐	Intended weight gain	☐	☐
Malaise (fatigue/tiredness)	☐	☐	Unintended weight gain	☐	☐
Night sweats	☐	☐			

INTEGUMENTARY (SKIN AND/OR BREAST)

	YES	NO		YES	NO
Acne	☐	☐	Rashes	☐	☐
Ulcer in old scar	☐	☐	Keloids (scar overgrowth)	☐	☐
Previous ulcer	☐	☐	Contact dermatitis (rash from something touching your skin)	☐	☐
Dryness	☐	☐			
Pruritus (itching)	☐	☐	Scars	☐	☐

ALLERGIC/IMMUNOLOGIC

	YES	NO		YES	NO
Lupus	☐	☐	Steroids	☐	☐
Rheumatoid	☐	☐	HIV	☐	☐
Scleroderma	☐	☐			

EYES

	YES	NO		YES	NO
Blind	☐	☐	Glasses	☐	☐
Macular degeneration	☐	☐	Cataracts	☐	☐
Optic neuritis	☐	☐	Cataract removal	☐	☐
Contact lenses	☐	☐			

EARS, NOSE, MOUTH, THROAT

	YES	NO		YES	NO
Dentures	☐	☐	Ear surgery	☐	☐
Hearing loss	☐	☐	Sinus surgery	☐	☐
Herpes simplex (cold sores)	☐	☐	Chronic sinusitis (recurrent sinusitis)	☐	☐
Recent respiratory infection	☐	☐	Partial dentures	☐	☐

RESPIRATORY

	YES	NO		YES	NO
			Asthma	☐	☐
Spontaneous pneumothorax (lung collapse)	☐	☐	COPD (emphysema)	☐	☐
Wear supplemental oxygen	☐	☐	Respiratory infection	☐	☐
Seasonal allergies	☐	☐	Tuberculosis	☐	☐
Chronic cough	☐	☐	Wheezing	☐	☐

CARDIOVASCULAR (HEART)					
	YES	**NO**		**YES**	**NO**
Shortness of breath with exertion	☐	☐	Palpitations	☐	☐
Angina (chest pain)	☐	☐	PND (have to sit up to catch your breath when sleeping	☐	☐
Arrhythmia (abnormal heartbeat)	☐	☐	Defibrillator	☐	☐
Heart failure (CHF)	☐	☐	Pacemaker	☐	☐
Hypertension (elevated blood pressure)	☐	☐			
Hypotension (abnormally low blood pressure)	☐	☐			
Orthopnea (difficulty breathing when lying flat on your back)	☐	☐			

CARDIOVASCULAR (PERIPHERAL CIRCULATION)					
	YES	**NO**		**YES**	**NO**
Varicose veins	☐	☐	Leg swelling	☐	☐
Arterial surgery	☐	☐	Claudication (leg pain with exercise)	☐	☐
Vein surgery	☐	☐	Rest pain	☐	☐
DVT (blood clot in leg/deep leg vein)	☐	☐	Necrosis/gangrene	☐	☐

GASTROINTESTINAL					
	YES	**NO**		**YES**	**NO**
Nausea/vomiting	☐	☐	Jaundice	☐	☐
Hiatal hernia	☐	☐	Hepatitis	☐	☐
Acid reflux	☐	☐	Blood in stools	☐	☐
Anorexia	☐	☐	Bowel incontinence	☐	☐
Bulimia	☐	☐	Constipation	☐	☐
Dysphagia (difficulty swallowing)	☐	☐	Diarrhea	☐	☐
Obesity	☐	☐	Stomach ulcers	☐	☐
Liver disease	☐	☐			

GENITOURINARY					
	YES	**NO**		**YES**	**NO**
Foley catheter	☐	☐	Nocturia (waking up to urinate)	☐	☐
Intermittent catheter	☐	☐	Chronic renal insufficiency	☐	☐
Suprapubic catheter	☐	☐	Kidney transplant	☐	☐
Cystostomy	☐	☐	Hemodialysis	☐	☐
Dysuria (pain with urination)	☐	☐	Peritoneal dialysis	☐	☐
Urinary frequency	☐	☐			

MUSCULOSKELETAL					
	YES	**NO**		**YES**	**NO**
Painful nails	☐	☐	Previous fracture	☐	☐
Myalgias (muscle pain)	☐	☐	Changes in feet	☐	☐
Arthritis	☐	☐	Alteration of gait	☐	☐

NEUROLOGICAL	YES	NO		YES	NO
Dizziness	☐	☐	Seizures	☐	☐
Focal headaches	☐	☐	Spinal cord injury	☐	☐
Weakness	☐	☐	Stroke	☐	☐
Muscular dystrophy	☐	☐	Syncope (passing out)	☐	☐
Parkinson's disease	☐	☐	TIA (mini stroke)	☐	☐

ENDOCRINE	YES	NO		YES	NO
Hypoglycemia (low blood sugar)	☐	☐	Addison's disease	☐	☐
Hyperglycemia (high blood sugar)	☐	☐	Cushing's disease	☐	☐
Thyroid disease	☐	☐			

HEMATOLOGIC/LYMPHATIC	YES	NO		YES	NO
Bruising	☐	☐	Hypercoaguable (clotting disorder)	☐	☐
Lymphedema	☐	☐	Family history of blood clots	☐	☐
Bleeding disorder	☐	☐			

PSYCHIATRIC	YES	NO		YES	NO
Impaired judgment	☐	☐	Claustophobia (fear of closed spaces)	☐	☐
Memory loss	☐	☐	Bipolar	☐	☐
Dementia/Alzheimers	☐	☐	Depression	☐	☐
Anxiety	☐	☐	Panic attacks	☐	☐

HYPERBARIC	YES	NO		YES	NO
Thoracic surgery	☐	☐	Cancer history	☐	☐
Optic neuritis	☐	☐	COPD/Emphysema	☐	☐
Congenital spherocytosis	☐	☐	Asthma	☐	☐
Ear surgery	☐	☐	Chronic sinusitis	☐	☐
Cataracts	☐	☐	Recent high fevers	☐	☐
Cataract removal	☐	☐	Recent administration of:		
Spontaneous pneumothorax (lung collapse)	☐	☐	1. Cisplatinum	☐	☐
Seizures	☐	☐	2. Adriamycin	☐	☐
Steroid use	☐	☐	3. Bleomycin	☐	☐
Previous hyperbaric treatment	☐	☐			